# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

12053

## CERTIFICATE OF DEATH

12039

1. **PLACE OF DEATH**
   a. COUNTY: WORCESTER — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BERLIN
   c. LENGTH OF STAY IN 1b: 45 YRS
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: N J.
   b. COUNTY: WORCESTER.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
   d. STREET ADDRESS: GAY ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First AUGUSTA Middle B. Last DENNIS

4. **DATE OF DEATH**: Month OCT. Day 9 Year 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 3 1885

9. AGE (In years last birthday): 76 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): POWELLVILLE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HIRAM BURBAGE

14. MOTHER'S MAIDEN NAME: LAURA POWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: MR. AUBREY C. DENNIS SR. Address: BERLIN MD

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hour.

422.1

DUE TO (b): Arteriosclerotic Cardio vascular disease — 4 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1930, 19.., to Oct 9, 1961., that (I) (we) last saw the deceased alive on Oct 9 1961., and that death occured at 12:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. R. Thomas M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/12/61

22c. PHYSICIAN'S NAME (Type): W. R. THOMAS

22d. ADDRESS: OCEAN CITY, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10 | 12 | 61

23c. NAME OF CEMETERY OR CREMATORY: BURBAGE CEM.

23d. LOCATION (City, town or county): POWELLVILLE (State): MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: OCT 16 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Timms

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

12054 12040

1. **PLACE OF DEATH**
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b: 70 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Berlin
d. STREET ADDRESS: R.F.D
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Henry — Middle: — Last: Downs

4. **DATE OF DEATH**: Month: Oct. — Day: 23 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 4, 1872

9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Whaleyville, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Downs

14. MOTHER'S MAIDEN NAME: Emmia Lou Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Mrs. Kathlene Winkler — Address: Phila Pa

18. **CAUSE OF DEATH** [Enter only one cause par line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
592X
DUE TO (b): Hypertension & Arterio-sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Chr. Nephritis

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 18, 1961, to Oct 23, 1961, that (I) (we) last saw the deceased alive on Oct 22, 1961, and that death occured at 7:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Chas. R. Law M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Oct. 24 - 1961

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: Berlin Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/25/61

23c. NAME OF CEMETERY OR CREMATORY: Taylorville

23d. LOCATION (City, town or county): Berlin (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: OCT 25 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Evans

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12055

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12041

1 FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: WORCESTER — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - POCOMOKE CITY
   c. LENGTH OF STAY IN 1b: 1 DAY
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): TWIN TOWERS MOTEL - U.S. ROUTE 13

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: DELAWARE
   b. COUNTY: KENT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMDEN
   d. STREET ADDRESS: COMMERCE STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

46X-3

3. NAME OF DECEASED (Type or print): First: REV. WILLIAM — Middle: JAMES — Last: ENNIS

4. DATE OF DEATH: Month: OCTOBER — Day: 8 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 25, 1905

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINISTER

10b. KIND OF BUSINESS OR INDUSTRY: CLERGY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES E. ENNIS SR.

14. MOTHER'S MAIDEN NAME: NAN M. BARNES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: MRS NAN ENNIS, COMMERCE ST. CAMDEN, DELAWARE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HANGING

DUE TO (c):

974X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Robert C. LaMar, M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10-9-61

EXAMINER'S NAME (Type): Robert C. LaMar, M. D., — Address (Street, city, town, or county): 104 Bay Street, Snow Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10-11-61

22c. NAME OF CEMETERY OR CREMATORY: PRESBYTERIAN

22d. LOCATION (City, town, or country) (State): POCOMOKE CITY, MARYLAND

23. FUNERAL DIRECTOR — ADDRESS: Henry J. Watson — POCOMOKE CITY, MD.

24a. REC'D BY REGISTRAR — DATE: OCT 13 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

12056

## CERTIFICATE OF DEATH

12042

**1. PLACE OF DEATH**
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OCEAN CITY
c. LENGTH OF STAY IN 1b: 1wk.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X WHALEYVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| CHARLES | DAVIS | HALL | OCT | 9 | 1961 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X] | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | | MARCH 1907 | 54 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CHIEF ENGINEER | ATLANTIC OIL TANKER | WHALEYVILLE Md | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HORACE HALL | CLARA E. HICKMAN |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | | Mrs. WILSON BRITTINGHAM BERLIN Md |

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acute coronary occlusion | instant |
| DUE TO (b) | Cor Pulmonale | years |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | Chronic emphysema. | " |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|
| | | | | | |

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 10/9, 1961, to 10/13, 1961, that (I) ~~(saw)~~ last saw the deceased alive on 10/13 19 61, and that death occured at 1 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Frank E. Gantz Jr. M.D.

ATTENDING PHYS. [X] ~~MED. DIRECTOR~~ [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Frank E. Gantz Jr. M.D.

22d. ADDRESS: 5 Bay Street Berlin, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| BURIAL | 10/12/61 | EVERGREEN | BERLIN MD |

24 FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: OCT 16 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Evans

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

12057 12043

1. **PLACE OF DEATH** a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill Rural #2 | c. LENGTH OF STAY IN 1b: 12yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residance before admission) a. STATE: Md | b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill Rural #2
d. STREET ADDRESS: | e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: George | Middle: R. | Last: Jefferson

4. **DATE OF DEATH**: Month: Oct. | Day: 19 | Year: 1961

5. SEX: Male | 6. COLOR OR RACE: White | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH: Jan. 23 - 1914 | 9. AGE (In years last birthday): 47-8-27 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver | 10b. KIND OF BUSINESS OR INDUSTRY: Long Distance | 11. BIRTHPLACE (County & State or foreign country): Milton, Delaware | 12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Arthur Jefferson | 14. MOTHER'S MAIDEN NAME: Estella Dickerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) Yes World War II | 16. SOCIAL SECURITY NO.: 222-03430 | 17. INFORMANT: Mrs Grace B. Jefferson | Address: Snow Hill Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchiogenic Carcinoma with
DUE TO (b): abdominal metastases — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1950, 19..., to 10/19/61, 19..., that (I) (we) last saw the deceased alive on 10/19/61 19..., and that death occured at 8:30 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Paul Cohen M.D. | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS: Snow Hill, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE THEREOF: Oct. 22/61 | 23c. NAME OF CEMETERY OR CREMATORY: Bowen Cemetery | 23d. LOCATION (City, town or county): Newark (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Elay E. Dennis | ADDRESS: Snow Hill Md | 25a. REC'D BY REGISTRAR DATE: OCT 23 '61 | 25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. P... may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12058 — 12044

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH** — a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   c. LENGTH OF STAY IN 1b: 15 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission) — a. STATE: md — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: C. — Middle: Irwin — Last: Jones

4. **DATE OF DEATH**: Month: Oct. — Day: 6 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 3 - 1894

9. AGE (In years last birthday): 67 4/12

IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bailie Conservation

10b. KIND OF BUSINESS OR INDUSTRY: Federal Government

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Dr Paul Jones

14. MOTHER'S MAIDEN NAME: Lillie G. Irwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give war or dates of service): Yes World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Dr Thomas L. Jones, Snow Hill Md

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

180X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of kidney — 2 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug., 19 61 to Oct., 19 61 that (I) (we) last saw the deceased alive on 10-6 19 61, and that death occured at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-7-61

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

22d. ADDRESS: Snow Hill, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 9/61
23c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
23d. LOCATION (City, town or county) (State): Snow Hill, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Elley E. Dennis — ADDRESS: Snow Hill, Md

25a. REC'D BY REGISTRAR — DATE: OCT 9 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

12059 12045

1. **PLACE OF DEATH**
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 35 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, If institution, residence before admission)
a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print) First: A. Middle: Pettyman Last: King

4. **DATE OF DEATH** Month: Oct. Day: 19 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 8 1896

9. AGE (In years last birthday): 64-11-11
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Home Building

11. BIRTHPLACE (County & State, or foreign country): Delmar, Delaware

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jesse King

14. MOTHER'S MAIDEN NAME: Lottie Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 218-30-1081

17. INFORMANT: Mrs. Esther L. King Address: Snow Hill, Md

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 min

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/16/61 19..... to 10/19/61 19....., that (I) (we) last saw the deceased alive on 10/19/61 19....., and that death occured at 9:30 P.M, from the causes and on the date stated above.

22a. SIGNATURE Paul Cohen M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS Snow Hill, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF Oct 23/61

23c. NAME OF CEMETERY OR CREMATORY Whatcoat Cemetery

23d. LOCATION (City, town or county) Snow Hill (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE Delay E. Dennis

ADDRESS Snow Hill, Md

25a. REC'D BY REGISTRAR DATE OCT 23 '61

25b. REGISTRAR'S SIGNATURE Lucian S. Purnell

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

12060 — 12046

1 (M)

**1. PLACE OF DEATH**
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress):

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before edmission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town): X Berlin
d. STREET ADDRESS: R.F.D. Libertytown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Dey | Yeer |
|---|---|---|---|---|---|
| Martha | Jane | Powell | Oct. | 5 | 1961 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 8. DATE OF BIRTH | 9. AGE (In yeers last birthdey) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | | Jan. 4, 1881 | 80 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | Own Home | Berlin Md (RFD | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Littleton Bethards | Cornelia Dennis |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No / No | No | Mr. T. B. Powell, Berlin Md R.F.D |

I

MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** (Enter only one cause per line for (e), (b), end (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e): Coronary Occlusion (Heart attack)
DUE TO (b): Chr. Myocarditis
DUE TO (c): Arterio-sclerosis

4201

Conditions, if any, which geve rise to immediete ceuse (e), steting the underlying ceuse last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Pert II of item 18.)

| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Dey, Yeer 19 | 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|---|
| | | | | | | |

21. **I certify** that (I) (this hospital) attended the deceased from Sept 20, 1961, to Oct 5, 1961, that (I) (we) last saw the deceased alive on Oct 4, 1961, and that death occured at 12.25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Chas R. Shaw M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Berlin Md

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY ~~OR CREMATORY~~ | 23d. LOCATION (City, town or county) | (State) |
|---|---|---|---|---|
| Burial | 10/7/61 | Riverside Cem. | Berlin | Md. |

| 24 FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Anna A. Burbage | Berlin Md | DATE OCT 9 '61 | Arthur S. Krauss |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12061 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 12047

M

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Snow Hill
c. LENGTH OF STAY IN 1b 1 mo +
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. #1

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill - Rural
d. STREET ADDRESS R.F.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Emory Middle Harvey Last Townsend
4. DATE OF DEATH Month Oct. Day 22 Year 1961
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 9 1902
9. AGE (If years last birthday) 59 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Timber Cutter
11. BIRTHPLACE (State or foreign country) Md Eden
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harvey Townsend
14. MOTHER'S MAIDEN NAME Alice McGrath
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Winifred Frances Townsend Address Snow Hill Md

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary disease 322.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis
DUE TO (c) Chronic Alcoholism
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Mentally deranged and a patient in Spring Grove Hospital
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE N. E. Dantonis M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) N. E. Dantonis M.D.
DATE SIGNED 10/22/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 24/61
22c. NAME OF CEMETERY OR CREMATORY Olivet Memory
22d. LOCATION (City, town, or county) (State) Snow Hill Rural Md

23. FUNERAL DIRECTOR'S SIGNATURE Ellis E. Dennis ADDRESS Snow Hill Md
24a. REC'D BY REGISTRAR DATE OCT 25 '61
24b. REGISTRAR'S SIGNATURE Clinton S. Evans

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12062

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12148

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylorville
c. LENGTH OF STAY IN 1b 4 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylorville X
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First James Middle Alfred Last White
4. DATE OF DEATH Month 10 Day 26 Year 1961
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 13 - 60
9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months 3 Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Olen White
14. MOTHER'S MAIDEN NAME Betty Jean Dennis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Betty Jean Dennis Address RR 2 Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia
493X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) Neglected treatment of Cold.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diarrhoea
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE N. E. Sartorius Sr. M.D.
EXAMINER'S NAME (Type) N. E. Sartorius
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 10/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 10/28/61
22c. NAME OF CEMETERY ~~OR CREMATORY~~ LINE CEM.
22d. LOCATION (City, town, or county) PITTSVILLE (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md.
24a. REC'D BY REGISTRAR DATE OCT 30 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

12063 / 12050

1. **PLACE OF DEATH**
   a. COUNTY: Worcester — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   c. LENGTH OF STAY IN 1b: 23 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: James — Middle: H. — Last: Young

4. **DATE OF DEATH**: Month: Oct — Day: 16 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 24 — 1875

9. AGE (In years last birthday): 85 10/12

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Newberry S. C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Philander Young

14. MOTHER'S MAIDEN NAME: Darby Ann Gant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 579/32/3663

17. INFORMANT: Mrs Pilberry Young 1314 - 25th St NW Apt 2 Washington, D.C.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): CVA — 5 days
DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 5, 19 61, to Oct 16, 19 61, that (I) (we) last saw the deceased alive on Oct 14 19 61, and that death occured at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10 - 18 - 61
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT M.D.
22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Oct 30/61 — 23c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery — 23d. LOCATION (City, town or county): Snow Hill (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Tilley & Timmis — ADDRESS: Snow Hill Md

25a. REC'D BY REGISTRAR — DATE: OCT 19 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Kenna

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60